DOMINION HILLS
FAMILY DENTISTRY

Jigmey L. Dorjee, DDS, PLLC
6011 Wilson Boulevard
Arlington, VA 22205

Patient Information

Name _____ (Last Name) _____ (First Name) _____ (Middle Initial)

Address _____ (Street Address) _____ (City) _____ (State) _____ (Zipcode)

Gender ☐ male ☐ female **Status** ☐ single ☐ married ☐ divorced

Date of Birth _____/_____/_____ **Age** _____ **E-Mail** _____

Social Security Number _____-_____-_____

Home Phone (_____) _____-_____ **Work Phone** (_____) _____-_____ **Cell** (_____) _____-_____

Emergency Contact _____ (Last Name) _____ (First Name) **Telephone** (_____) _____-_____

▶How did you hear about our office? ☐ Insurance Company/Website ☐ Phone Book ☐ Advertisement ☐ Referral by family member or friend

▶ If referred by family member or friend please provide his/her name: _____

▶ Fill out this section if the patient is a minor or has a legal guardian

Legal Guardian _____ _____ **Relationship to patient** _____

Insurance Information

Ins. Co. Name _____ **Group#** _____ **ID#** _____

Insurance Co. Phone _____

Name of Employer _____ **Telephone** (_____) _____-_____

▶ Fill out this section if the insurance coverage for the patient is provided by another family member

Name of Insured _____ (Last Name) _____ (First Name) **Relationship to patient** _____

Social Security # _____-_____-_____ **DOB:** ____/____/_____ **Is he/she currently a patient in our practice?** ☐ yes ☐ no

Patient Medical History

1. Are you under medical treatment now? ☐ yes ☐ no
2. Have you been hospitalized in the past 5 years for any serious illness or surgical operation? ☐ yes ☐ no
3. Do you use tobacco? ☐ yes ☐ no
4. Do you use any controlled substance(s)? ☐ yes ☐ no
5. Are you wearing contact lenses? ☐ yes ☐ no

6. If you are currently taking any medications, please list: _____

7. If you are allergic to any of the following, please specify:

☐ Penicillin or any other Antibiotics
☐ Barbiturates
☐ Sulfa Drugs
☐ Sedatives
☐ Local Anesthetics
☐ Latex Rubber

8. Do you have or have you had any of the following?

☐ High Blood Pressure
☐ Heart Attack
☐ Rheumatic Fever
☐ Swollen Ankles
☐ Fainting / Seizures
☐ Asthma
☐ Low Blood Pressure
☐ Epilepsy / Convulsions
☐ Leukemia
☐ Diabetes
☐ Kidney Diseases
☐ Heart Murmur
☐ Thyroid Problem
☐ Heart Disease
☐ Cardiac Pacemaker
☐ Angina
☐ Anemia
☐ Emphysema
☐ Radiation Therapy
☐ Glaucoma
☐ Recent Weight Loss
☐ Liver Disease
☐ Heart Trouble
☐ Respiratory Problems
☐ Mitral Valve Prolapse
☐ AIDS or HIV Infection
☐ Other _____

9. Women Only:
a. Are you Pregnant or think you may be pregnant? ☐ yes ☐ no

Please Turn the page

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Patient Dental History

1. Which of the following services are you interested in? (checkmark all that applies)

☐ Regular cleaning & check-up	☐ Cosmetic dentistry	☐ Bleaching	☐ Orthodontics (Braces)
☐ Reconstructive work (crown & bridges)	☐ Implants	☐ Sedation dentistry	☐ Consultation

2. Do you like your smile?	☐ yes ☐ no			
3. How often do you brush?	☐ More than once a day	☐ Once a day	☐ few times a week	☐ Do not brush
4. How often do you floss?	☐ More than once a day	☐ Once a day	☐ few times a week	☐ Do not floss

5. Are your teeth sensitive to hot or cold liquids / foods?	☐ yes ☐ no
6. Are your teeth sensitive to sweet or sour liquids / foods?	☐ yes ☐ no
7. Do you feel pain to any of your teeth?	☐ yes ☐ no
8. Do you have any sores or lumps in or near your mouth?	☐ yes ☐ no
9. Do your gums bleed while brushing or flossing?	☐ yes ☐ no
10.Do you clench or grind your teeth?	☐ yes ☐ no
11. Do you have frequent headaches?	☐ yes ☐ no
12. Have you had any orthodontic treatment?	☐ yes ☐ no
13. Do you have problem opening or closing your jaw?	☐ yes ☐ no
14. Do you bite your lips or cheeks frequently?	☐ yes ☐ no
15. Have you ever had any difficult extractions in the past?	☐ yes ☐ no
16. Have you ever had any prolonged bleeding following extractions?	☐ yes ☐ no
17. Do you wear dentures or partials?	☐ yes ☐ no

Assignment and Authorization

I hereby consent to x-rays, laboratory procedures, anesthesia, and dental or surgical treatments rendered which Dominion Hills Family Dentistry considers or advises in the treatment of my case, and I guarantee payments of the charges incurred. I hereby assign and authorize payment of insurance benefits directly to Jigmey L. Dorjee, DDS, PLLC T/A Dominion Hills Family Dentistry and hereby authorize this dental practice to release information requested on insurance forms. I understand that payment is due at the time service is rendered, and Dominion Hills Dentistry will submit my insurance claims on my behalf. I understand that If there is a balance on my account that has not been paid by the due date, Dominion Hills Family Dentistry may elect to turn the account over for collection. Should collection become necessary, the responsible party agrees to pay all additional collection and legal fees, including attorney fees and court costs. In addition, I understand that a minimum of 24-hour notice is required to cancel my scheduled appointment(s). I hereby authorize Dominion Hills Family Dentistry to charge my account $50 per missed appointment. Dominion Hills Family Dentistry reserves the right to render inactive any patient that cancels two or more appointments.

Signature: _____ **Date:** _____/_____/_____

Acknowledgement of Receipt of Notice of Privacy Practices

***you may refuse to sign this acknowledgement**

I _____ have received a copy of this office's Notice of Privacy Practices.
Please print name

Signature: _____ **Date:** _____/_____/_____

▶ Office Use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtain because:

☐ Individual refused to sign
☐ Communication barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowlegement

☐ Other (Please specify) _____